Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss quality of care in the nation's 17,000 nursing homes for their 1.6 million residents. The federal government has a major stake in ensuring nursing home care quality and will have paid homes an estimated $39 billion in fiscal year 2000. Over 2 years ago, this Committee held a hearing to discuss nursing home care in California. Troubled by our findings of poor care in the state's homes and weak oversight by the Health Care Financing Administration (HCFA) and the state oversight agency,[1] the Committee held additional hearings on nursing home care and oversight nationwide. These hearings prompted the Administration to announce a series of nursing home quality initiatives and the states to initiate greater oversight activity. In our reports and testimony since July 1998, we identified the following key weaknesses:

- State surveyors—the professional staff in state agencies who inspect nursing homes—understated the extent of serious care problems, which are those technically classified as causing "actual harm" to residents and those placing residents' health, safety, or lives in "immediate jeopardy." The understatement problem reflected procedural weaknesses in the states' performance of surveys, or inspections, of the homes and the predictable timing of these surveys.

- Complaints by residents, family members, or facility staff alleging harm to residents remained uninvestigated for weeks or months.

- When serious deficiencies were identified, federal and state enforcement policies did not ensure that the deficiencies were addressed and remained corrected.

- Federal mechanisms for overseeing state monitoring of nursing home quality were limited in their scope and effectiveness.

In providing you information today on the status of federal and state efforts to ensure improvements in nursing home quality since the identification of these weaknesses and introduction of the quality initiatives, my remarks will focus on (1) progress in improving the detection of quality problems during annual surveys, (2) how the prevalence of identified problems has changed, (3) the status of efforts to strengthen states' complaint investigation processes and federal enforcement policies, and (4) additional activities occurring at the federal level to improve oversight of states' quality assurance activities. These remarks are based on a report we are issuing today that addresses these issues in more detail.[2]

Overall, the series of federal quality initiatives begun 2 years ago has produced a range of nursing home oversight activities that need continued federal and state commitment to

---

[1] California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (GAO/HEHS-98-202, July 27, 1998).

[2] Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives (GAO/HEHS-00-197).

reach their full potential. Certain of the federal initiatives seek to strengthen the rigor with which states conduct their required annual surveys of nursing homes. Others focus on the timeliness and reporting of complaint investigations and the use of management information to guide federal and state oversight efforts. The states are in a period of transition with regard to the implementation of these initiatives, partly because HCFA is phasing them in and partly because states did not begin their efforts from a common starting point. HCFA's efforts toward improving the oversight of states' quality assurance activities have begun but are unfinished or need refinement.

The results from states' recent standard surveys provide a picture of federal and state efforts in progress. On average, a slightly higher proportion of homes were cited nationwide for actual harm and immediate jeopardy deficiencies on their most recent survey than were cited during the previous survey cycle. While it was expected that more deficiencies would be identified owing to the increased rigor in nursing home inspections, the survey results could also suggest that nursing homes may not have made sufficient strides to measurably improve residents' quality of care. The results also show a wide variation across states in the proportion of homes with identified serious care deficiencies. While these proportions are expected to vary somewhat from one state to another, the wide range may reflect the extent to which the inspection of homes is inconsistent across states. In our view, the full potential of the nursing home initiatives to improve quality will more likely be realized if greater uniformity in the oversight process can be achieved.

BACKGROUND

Oversight of nursing homes is a shared federal and state responsibility. On the basis of statutory requirements, HCFA defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs and contracts with states to certify that homes meet these standards through annual inspections and complaint investigations. The "annual" inspection, called a survey, which must be conducted on average every 12 months and no less than every 15 months at each home, entails a team of state surveyors spending several days in the home to determine whether care and services meet the assessed needs of the residents. HCFA establishes specific protocols, or investigative procedures, for state surveyors to use in conducting these comprehensive surveys. In contrast, complaint investigations, also conducted by state surveyors within certain federal guidelines and time frames, typically target a single area in response to a complaint filed against a home by a resident, the resident's family or friends, or nursing home employees. Quality-of-care problems identified during either standard surveys or complaint investigations are classified in 1 of 12 categories according to their scope (the number of residents potentially or actually affected) and their severity (potential for or occurrence of harm to residents).

Ensuring that documented deficiencies are corrected is likewise a shared responsibility. HCFA is responsible for enforcement actions involving homes with Medicare certification—about 86 percent of all homes. States are responsible for enforcing standards in homes with Medicaid-only certification—about 14 percent of the total. Enforcement actions can involve, among other things, requiring corrective action plans,

monetary fines, denying the home Medicare and Medicaid payments until corrections are in place, and, ultimately, terminating the home from participation in these programs. Sanctions are imposed by HCFA on the basis of state referrals. States may also use their state licensure authority to impose state sanctions.

HCFA is also responsible for overseeing each state survey agency's performance in ensuring quality of care in its nursing homes. One of its primary oversight tools is the federal monitoring survey, which is required annually for at least 5 percent of the nation's Medicare- and Medicaid-certified nursing homes. HCFA also maintains a central database—the On-Line Survey, Certification, and Reporting (OSCAR) System—that compiles, among other information, the results of every state survey conducted on Medicare- and Medicaid-certified facilities nationwide.

IMPROVEMENTS MADE IN ANNUAL SURVEY METHODS

Federal initiatives were introduced to strengthen the rigor with which states conduct required annual surveys of nursing homes. The states we visited have begun to use the new methods introduced by the initiatives to spot serious (actual harm and immediate jeopardy) deficiencies when conducting surveys,[3] but HCFA is still developing important additional steps, some of which will not be introduced until 2002 or 2003. HCFA and the states have also attempted to address problems with the predictable timing of the surveys, but improvements made have been modest at best.

Improvements Made in Standard Survey Methodology

In our prior work, we found that surveyors often missed significant care problems—such as pressure sores, malnutrition, and dehydration—because the methods they used to select a sample of a home's residents for review lacked sufficient rigor. To select the sample, surveyors rely on information from prior surveys, a facility-prepared census of residents grouped by medical condition, and observations of residents made during an initial tour of the home. Certain HCFA initiatives effective July 1999 were intended to introduce greater objectivity in the sample selection process. Under these initiatives, state survey agencies are instructed to use "quality indicators" to guide their decisions on where to focus their investigative efforts. Quality indicators are essentially numeric warning signs that flag the prevalence of care problems, such as greater-than-expected instances of weight loss, dehydration, or pressure sores. These outcome measures enable surveyors to rank the facility against other nursing homes in the state and the nation on 24 care dimensions. In selecting a sample of residents for review, surveyors use information developed from the quality indicators, which they later supplement with personal observations.

---

[3]In addition to visiting California, Missouri, Washington, and Tennessee, we contacted officials in Maryland and Michigan, two states in which we had conducted reviews previously.

In conjunction with the use of quality indicators, HCFA also instructed surveyors to begin using a new set of investigative protocols, or procedural instructions, intended to make the facility inspections more thorough and more uniform, thus reducing the variation in the conduct of surveys within and across states. However, HCFA's new guidance on the use of quality indicators and protocols does not address all of the identified weaknesses in the survey methodology. HCFA needs to ensure the reliability of the data on which the quality indicators are based, because the data are self-reported by the nursing homes and are not independently verified. Also, in our view, the size of the sample of resident cases reviewed may not be sufficient to establish the prevalence of certain identified problems. HCFA plans to introduce additional survey methodology guidance in 2002 or 2003.

Efforts to Reduce Predictability in the Timing of Standard Surveys Have Been Modest

Surveyors can also miss care problems during the standard surveys when the timing of these visits is predictable, allowing facilities time to present themselves at inspection in ways that do not represent the home's normal routines or care practices. To address the predictability problem, HCFA required states to start at least 10 percent of standard surveys outside normal workday hours—either early morning, evening, or on weekends—beginning January 1, 1999. HCFA also instructed the states to avoid, if possible, scheduling a home's survey for the same month as the one in which the home's previous standard survey was conducted.

HCFA's tracking of states' progress in implementing the off-hour survey requirement has not been timely. Although the agency instructed states to begin the off-hour initiative in January 1999, it did not modify its national OSCAR database to enable identifying such surveys until 8 months later, in August 1999, and did not instruct the states to enter the data on such surveys until February 2000. It was another 6 months, in August 2000, before HCFA began contacting those states that fell short of meeting the 10-percent requirement to elicit improved performance.

Our analysis of successive standard surveys shows that many homes in the six states we reviewed continued to have their annual inspection within a short time from the anniversary of their previous inspection or at the end of the maximum allowed 15-month period between consecutive surveys. Both circumstances allow a home to anticipate when their survey will occur. (See table 1.)

Table 1: Predictability of Surveys

State	Number of homes	Percentage surveyed within 15 days of anniversary of previous survey	Percentage surveyed 14-15 months after previous survey	Percentage surveyed 15-16 months after previous survey	Total percentage of surveys considered predictable
California	1,301	8.0	31.4	15.0	54.4
Maryland	243	4.9	14.8	9.0	28.7
Michigan	434	14.0	14.3	9.9	38.2
Missouri	476	11.1	13.9	8.8	33.8
Tennessee	351	56.1	0	0	56.1
Washington	278	15.1	17.6	1.0	33.7

Note: Data were extracted from OSCAR in August 2000. Homes not showing a prior survey date were not included in this analysis.

Over half the surveys in Tennessee were conducted within 15 days of the anniversary of the previous standard survey.[4] In California and Maryland, where a large share of the surveys occurred late in the 15-month cycle, officials explained that an increased emphasis on conducting complaint investigations more promptly drew on the same surveyor staff who perform the annual surveys, which resulted in postponing many of the surveys until as late as possible.

In our view, the off-hour scheduling of surveys is too limited a step to effectively restrict homes' opportunities to prepare for their annual inspection. As we recommended in our July 1998 report, the predictability problem could be mitigated by segmenting the surveys into more than one visit. Currently, surveys are comprehensive reviews that can last several days and entail examining not only a home's compliance with resident care standards but also with administrative and housekeeping standards. Dividing the survey into segments performed over several visits, particularly for those homes with a history of serious deficiencies, would increase the presence of surveyors in these homes and provide an opportunity for surveyors to initiate broader reviews when warranted. With a segmented set of inspections, homes would not be able to relax their efforts to provide quality care because they could no longer rely on the likelihood of the next surveyor's visit being 12 to 15 months away.

[4]Until recently, Tennessee law limited the annual inspection time frame to 12 months. In May 2000, Tennessee modified this law to permit nursing homes to be surveyed at a maximum interval of 15 months.

INCREASE IN IDENTIFIED DEFICIENCIES DIFFICULT TO INTERPRET

In reviewing the identification of actual harm and immediate jeopardy deficiencies, we conducted an analysis of homes cited for these deficiencies in the periods before and after the introduction of the quality initiatives. We found the following:

- Overall, the proportion of homes with documented actual harm and immediate jeopardy deficiencies increased marginally, although some states experienced a decrease in the number of homes with these deficiencies.

- The variation across states in the share of homes cited for actual harm and immediate jeopardy deficiencies after the introduction of the initiatives remained wide—ranging from under 11 percent of homes in Maine to 58 percent of homes in Washington—but narrowed slightly from the period before the initiatives.

These results suggest that states may have become more rigorous in their identification and classification of serious deficiencies. The results could also indicate that, nationwide, the volume of such deficiencies may have increased slightly, which may be attributable in part to reported facility staff shortages during this time period. With regard to the variation in the shares of homes cited for serious deficiencies, the expectation is that, as the performance of standard surveys becomes more consistent across states, differences in results will shrink. (See table 2.)

Table 2: Percentage of Homes With Actual Harm and Immediate Jeopardy Deficiencies Before and After Implementation of the Quality Initiatives

State[a]	Number of homes surveyed[b] (1/99 to 7/00)	Percentage of home with actual harm and immediate jeopardy deficiencies: Before initiatives (1/97 to 7/98)	After initiatives (1/99 to 7/00)	Percentage point difference
Increase of 5 percentage points or greater				
Arizona	125[b]	17.2	36.8	19.6
Arkansas	253[b]	14.7	30.8	16.1
New York	606	13.3	27.6	14.3
Tennessee	353	11.1	24.1	13.0
North Carolina	409	31.0	42.1	11.1
New Jersey	336[b]	13.0	23.8	10.8
Oregon	157	43.9	53.5	9.6
Massachusetts	541	24.0	32.9	8.9
West Virginia	144	12.3	20.1	7.8
Indiana	581	40.5	48.2	7.7
Louisiana	365[b]	12.7	20.3	7.6
Georgia	364	17.8	25.0	7.2
Mississippi	196[b]	24.8	31.6	6.8
Oklahoma	394[b]	8.4	15.0	6.6
Colorado	229	11.1	16.6	5.5
Maryland	188[b]	19.0	24.5	5.5
Missouri[c]	565	21.0	25.7	4.7
Change of less than 5 percentage points				
Maine	124	7.4	10.5	3.1
Minnesota	437	29.6	32.5	2.9
Texas	1313	22.2	24.9	2.7
Michigan	442	43.7	45.9	2.2
Nation	**16,854**	**27.7**	**29.5**	**1.8**
Pennsylvania	774	29.3	30.7	1.4
Illinois	891	29.8	31.1	1.3
South Carolina	176	28.6	29.5	0.9
Connecticut	260	52.9	53.5	0.6
Montana	105	38.7	39.0	0.3
California	1,301[b]	28.2	28.2	0.0
Wisconsin	424	17.1	14.6	-2.5
Ohio	995	31.2	28.6	-2.6
Kentucky	306	28.6	25.2	-3.4
Decrease of 5 percentage points or greater				
Virginia	282	24.7	19.5	-5.2
Washington	281	63.2	57.7	-5.5
Nebraska	241	32.3	26.6	-5.7
Alabama	225	51.1	41.3	-9.8
Kansas	404[b]	47.0	36.9	-10.1
South Dakota	112[b]	40.3	29.5	-10.8
Florida	746	36.3	21.7	-14.6
Iowa	428[b]	39.2	22.7	-16.5

[a]Twelve states and the District of Columbia were excluded from this analysis because they had fewer than 100 homes surveyed since January 1999.

[b]The number of homes cited in this state for the 1999-2000 period differed by 10 percent or more from the number documented for the prior period. In part, these differences are explained by the fact that some states have still not recorded the results of a home's most recent survey in OSCAR.

[c]Although our work in Missouri focused on the agency that is responsible for surveying nonhospital-based nursing homes, the state's number of homes shown in this table also includes hospital-based facilities.

In July 2000, HCFA released a report indicating a direct relationship between low nursing home staffing levels and poor quality of care.[5] While recruiting and retaining staff have been long-standing concerns, state officials and nursing home surveyors we interviewed recently believe the problem has become acute and has directly affected the quality of care provided to nursing home residents. Reasons cited for the growing staffing problems include a highly competitive job market resulting from a robust economy combined with lower wages and benefits for nurse's aides compared with other health and non-health sector opportunities, and increased demand for staff from alternatives to nursing homes, such as assisted living facilities.[6] We identified 16 states that have increased their Medicaid payments to supplement nursing home staff wages and benefits by a specific amount.[7]

COMPLAINT AND ENFORCEMENT PROCESSES ARE IMPROVING, BUT MORE TIME AND REFINEMENT NEEDED TO REACH GOALS

The states we contacted have also made strides in addressing complaint investigations, but not enough time has elapsed to fully implement or evaluate the success of these efforts. For example, the states in our review were not yet investigating within 10 days all complaints that allege actual harm to a resident, as HCFA's complaint investigation initiative now requires, but they have efforts under way to reach that goal. Similarly, HCFA has begun applying stronger enforcement policies to ensure that homes comply with federal standards, but it is too early in their implementation to determine whether these policies have been effective.

The states we contacted generally attributed their inability to meet the 10-day investigative time frame for serious allegations to an increase in the number of complaints received, limited staffing levels, and competing priorities, particularly the need to complete standard surveys within the required cycle. Nevertheless, the increased attention HCFA and the states have placed on conducting complaint

---

[5]See Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes ,Vol. I-III (Baltimore, Md.: HCFA, Summer 2000).

[6]A 1996 Institute of Medicine study documented similar reasons for turnover and retention problems among nurses aides. Institute of Medicine, Nursing Staff in Hospitals and Nursing Homes: Is it Adequate? (Washington, D.C.: National Academy Press, 1996).

[7]"Wage pass-throughs" provide a specific amount or percentage increase in reimbursement, earmarked typically for the salaries, benefits, or both of direct care staff—such as nurses and nurse's aides. States that have enacted wage pass-throughs include Arkansas, California, Connecticut, Florida, Kansas, Maine, Michigan, Minnesota, Montana, Oklahoma, South Carolina, Texas, Utah, Vermont, Virginia, and Wisconsin. Four other states—Louisiana, Maryland, Massachusetts, and Missouri—only recently passed legislation and have not yet implemented their wage pass-through programs.

investigations in the past 18 months has resulted in some improvements. For example, among the states in our review, we noted the following:

- Increased survey resources. Several states have increased, or plan to increase, the number of surveyors, some of whom will be assigned specifically to conduct complaints investigations. Michigan created a complaints investigation team of 11 surveyors, representing about 10 percent of the state's total surveyor staff. Washington plans to increase its number of complaints investigators from 8 to 13.

- Improvements in classifying complaints. All the states in our study require the seriousness of complaints to be determined by an experienced surveyor; Tennessee and Washington further require that the surveyor be a licensed nurse. In Missouri, individuals without survey experience had been responsible for classifying complaints, but now an experienced district office surveyor, normally a nurse, does so. Nevertheless, the proper classification of complaints remains an important issue. For example, Michigan's small number of complaints alleging actual harm—17 of 902 complaints (2 percent) in the last half of 1999—raises questions about whether the complaints were appropriately classified. For the same time period, Maryland put 62 percent of its complaints in the actual harm category.

- Organizational changes. To improve control and oversight of complaints, both Maryland and Michigan have consolidated their nursing home complaint and survey activities into one office under a single manager. Michigan also added a manager responsible for direct oversight of the complaint investigation team. Missouri created a state complaint coordinator to ensure that complaints are handled in a timely manner.

- Upgrade of information systems. Several states are automating their information systems to track complaints more effectively. The use of these data systems enables oversight officials to ensure that states are complying with HCFA guidance on setting complaint investigation priorities and meeting prescribed investigation time frames. For example, Missouri plans to implement a new automated system in 2001 that should significantly improve management's ability to track the status and results of complaint investigations. Tennessee also is implementing a new system that will replace the manual tracking of complaints. Washington has modified its complaint tracking system to facilitate its use by the state agency's district offices.

HCFA intends to issue more detailed guidance to the states in 2001 as part of its complaint process improvement project. Among other things, the project will identify "best practices" for complaint investigations.

The Congress and the Administration recognized that additional resources were needed to address expanded workloads associated with implementing the nursing home quality

initiatives.[8] As a result, the Medicare survey and certification budget was increased in fiscal years 1999 and 2000, of which $8 million and $23.5 million, respectively, reflected funding for the nursing home initiatives. According to states' expenditure reports on the fiscal year 1999 allocation, much of the $8 million appears to have gone unspent. However, a precise accounting of these funds is not available. On the one hand, discrepancies between the initiatives expenditure reports and the separate reports that capture all survey and certification expenditures (including the initiatives) raise the possibility that some states may have spent their initiatives funding but failed to account separately for initiatives expenditures as required by HCFA. On the other hand, the two sets of reports indicate that 28 states did not use their full fiscal year 1999 initiatives or survey and certification funding allocations, suggesting that a substantial portion of the $8 million was not used for the nursing home initiatives in fiscal year 1999. States have not yet submitted final expenditure reports regarding the fiscal year 2000 initiative allocations.

HCFA has also strengthened the enforcement options available to impose sanctions on nursing homes that are cited for actual harm and immediate jeopardy violations. In September 1998, HCFA modified its policy to require that states refer for immediate sanctions any nursing home with a pattern of harming a significant number of residents on successive surveys. Effective December 15, 1999, HCFA expanded this policy to include deficiencies that harmed only one or a small number of residents on successive surveys. In an earlier report, we estimated that this change could increase the percentage of homes referred immediately for sanctions from approximately 1 percent to as many as 15 percent of homes nationally.[9] Early indications from some states are that their referrals of homes to HCFA for sanctions are on the rise.

Additional funds were also provided in fiscal years 1999 and 2000 to hire more federal staff to reduce the large number of pending appeals by nursing homes and collect assessed fines faster. The expectation is that the more expeditious resolution of appeals will heighten the deterrent effect of civil fines. It is too early to assess the effect of the additional funding on the number of pending appeals because the new staff were only hired within the past year and other changes in enforcement policy are expected to increase the volume of nursing home appeals.

---

[8]HCFA determined that additional state resources would be consumed by initiatives requiring states to better target and monitor poorly performing homes and to investigate any complaint alleging actual harm within 10 days of complaint receipt. HCFA also anticipated that the use of quality indicators would increase surveyor preparation time before visiting a nursing home and that this could lead to a net increase in total survey time.

[9]Nursing Homes: HCFA Initiatives to Improve Care Are Under Way But Will Require Continued Commitment (GAO/T-HEHS-99-155, June 30, 1999), p. 12.

IMPROVEMENTS IN FEDERAL OVERSIGHT OF NURSING HOME QUALITY ARE UNDER WAY OR PLANNED

To improve nursing home oversight at the federal level, HCFA has begun making changes, largely in how its regional offices and central office interact, in information management capabilities, and in nursing home oversight funding.

HCFA has made organizational changes to address past consistency and coordination problems among its central office and 10 regional offices. In our earlier work, we raised concerns about the diffusion of accountability among HCFA's central and regional office components responsible for monitoring states' survey agencies. The absence of clear and connected organizational lines of authority weakened regional office oversight of the state agencies and blurred accountability when problems arose. Regional offices and state surveyors could not be assured of providing or receiving consistent information on nursing home oversight policies and practices.

To address the problems of coordination and accountability, HCFA has made or is in the process of making organizational changes. For example, in May 2000 it established a policy oversight board covering nursing home survey and certification issues. The board's composition, which includes both regional office and central office representatives, is intended to improve communication and coordination among senior HCFA managers responsible for nursing home oversight. HCFA has also designated two officials, one from the central and one from a regional office, to direct the daily management of nursing home oversight activities. The intention is to provide a national perspective on oversight activities and help ensure consistency across regions. In June 2000, the agency established a clearinghouse, with representatives from HCFA's central office, regional offices, and state survey agencies, to ensure that regional office directives to states are consistent with national policy.

HCFA also intends to intensify its use of management information to verify and assess states' oversight activities and view more closely the performance of the homes themselves. For one thing, it plans to make the federal OSCAR database more user-friendly. Although OSCAR provides extensive information about state surveys—such as the timing of surveys, the deficiencies cited, and the time spent conducting various survey activities—computer programming knowledge is typically needed to conduct data analysis. Unless the data are analyzed, regulators will not have a complete picture of an individual facility's performance record, of the facility's performance relative to others in the state, and of state and regional oversight performance relative to their counterparts nationwide. Refinements will allow users to access such information with much greater ease and are expected to be completed by the summer of 2001.

In another effort to enhance the use of management information, HCFA recently directed the regional offices to prepare and submit periodically 18 "tracking" reports on areas that measure both state and regional office performance. Examples include weekly reports on nursing home terminations, monthly reports on surveys for "special focus" facilities, quarterly reports on meeting OSCAR data entry deadlines, semiannual tallies of state

surveys that find homes deficiency-free, and annual analyses of the most frequently cited deficiencies by states. HCFA will begin using these reports effective October 2000. In standard format, the reports will enable regions to make comparisons within and across states. This information should help surface problems and identify the need for intervention, either on the part of the HCFA regional or central office.

The value of these data, which were previously available but not systematically reviewed, is illustrated by the case of Missouri's "deficiency-free" homes in the 1999-2000 survey cycle that we reviewed. Had HCFA oversight officials cross-checked Missouri's survey results with the homes' history of complaint allegations, it would have found that the state's 84 supposedly deficiency-free homes had received 605 complaints. One of these homes had 39 complaints and 19 homes had 10 or more complaints. Significant numbers of these complaints were substantiated when investigated.

HCFA's efforts remain weak in one area that is rich in the potential to provide useful information—federal monitoring surveys. HCFA conducts two types of federal monitoring surveys to assess how well states are performing their standard annual inspections. One type is called a comparative survey, in which a team of federal surveyors conducts a complete survey of a nursing home—subsequent to and independent of the state's standard survey of that home—and compares the results of the two surveys. The other type is called an observational survey, in which generally one or two federal surveyors accompany state surveyors to a nursing home either as part of the home's annual standard survey, as part of a follow-up visit to a home found to be out of compliance with federal standards, or as part of a complaint investigation. In an observational survey, federal surveyors watch state surveyors perform a variety of tasks, discuss their observations with the state surveyors under review, and later provide a written performance rating to the surveyors' supervisors.

Last November, we reported that the observational surveys, which HCFA relied on most of the time, were of limited value in evaluating the adequacy of the state survey process because they may have caused state surveyors to perform their tasks more attentively than they would have if the federal observers had not been present. At the same time, HCFA's use of comparative surveys was negligible, despite their merit in providing a more objective measure of state surveyors' performance. Between October 1998 and May 2000, 70 percent of the 157 federally conducted comparative surveys found more serious care problems than did the state surveys of the same facilities. In our November 1999 report, we recommended that HCFA increase the proportion of federal monitoring surveys conducted as comparative surveys.[10] In response, HCFA is considering either increase the number of federal surveyors available to conduct comparative surveys or narrowing their scope to allow more such surveys to be done.

HCFA is also planning to change its process of allocating funding for survey and certification activities to the states. Under the current budget process, funding requests

---

[10]Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality (GAO/HEHS-00-6, Nov. 4, 1999).

and state funding allocations are based on states' historical activity levels and costs. Such a process rewards states that spent substantial amounts in the past and holds down funding for those that historically spent little on these activities. HCFA's fiscal year 2001 annual performance plan, as required under the Government Performance and Results Act of 1993, establishes a performance goal of moving from the current budget process to a need-based process. HCFA proposes developing national standard survey measures and costs that would be used to price the workload for each state survey agency.

CONCLUSIONS

Over the past 2 years, the considerable attention focused on nursing home quality of care has resulted in heightened awareness and responses at many levels—the federal government, the states, and the nursing home industry. Many of the resulting new policies and practices have only recently been instituted and will need time to take hold. For example, better detection and classification of serious deficiencies through the standard survey process will require further methodological developments aimed at improving the selection of resident cases for review. New efforts will be required to reduce the opportunities for homes to predict the timing of and prepare for these inspections. States' efforts to expedite complaint investigations and systematize the reporting of investigation results are at various stages of completion. More time must elapse to know whether strengthened federal enforcement policies in fact create the incentives and environment that discourage poor care and ensure permanent corrections. Similarly, with respect to improved federal oversight, the effectiveness of recent internal HCFA reorganizations and management information reporting enhancements can only be judged in the months to come.

Vigilance by both state and federal officials must be unrelenting to ensure the safety and well-being of the nation's nursing home residents. The performance of oversight can neither be taken for granted nor relaxed, which means that neither HCFA nor the states can afford to lose their current momentum. The Congress, too, can play an important role in keeping the spotlight on oversight agencies and the nursing home industry to achieve quality improvements. We will continue to assist this Committee and the Congress as needed to assess progress on these issues.

* * * *

Mr. Chairman and Members of the Committee, this concludes my prepared statement. I will be happy to answer any questions you may have.

GAO CONTACTS AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call Kathryn G. Allen at (202) 512-7118 or Walter Ochinko at (202) 512-7157. Connie Peebles Barrow, Jack Brennan, Hannah Fein, Robert Lappi, Peter Oswald, Peter Schmidt, Don Walthall, and Opal Winebrenner also made contributions to this statement.

RELATED GAO PRODUCTS

Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives (GAO/HEHS-00-197, Sept. 28, 2000).

Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality (GAO/HEHS-00-6, Nov. 4, 1999).

Nursing Homes: HCFA Should Strengthen Its Oversight of State Agencies to Better Ensure Quality Care (GAO/T-HEHS-00-27, Nov. 4, 1999).

Nursing Home Oversight: Industry Examples Do Not Demonstrate That Regulatory Actions Were Unreasonable (GAO/HEHS-99-154R, Aug. 13, 1999).

Nursing Homes: HCFA Initiatives to Improve Care Are Under Way but Will Require Continued Commitment (GAO/T-HEHS-99-155, June 30, 1999).

Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit (GAO/HEHS-99-157, June 30, 1999).

Nursing Homes: Complaint Investigation Processes in Maryland (GAO/T-HEHS-99-146, June 15, 1999).

Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents (GAO/HEHS-99-80, Mar. 22, 1999).

Nursing Homes: Stronger Complaint and Enforcement Practices Needed to Better Ensure Adequate Care (GAO/T-HEHS-99-89, Mar. 22, 1999).

Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards (GAO/HEHS-99-46, Mar. 18, 1999).

California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (GAO/HEHS-98-202, July 27, 1998).

California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes With Serious Care Violations (GAO/T-HEHS-98-219, July 28, 1998).

(201108)